STATEMENT OF CONSIDERATION RELATING TO
907 KAR: 12:020

Department for Medicaid Services
Not Amended After Comments

(1) A public hearing regarding 907 KAR 12:020 was not requested and; therefore, not held.

(2) The following individuals submitted written comments regarding 907 KAR 12:020:

Name and Title	Organization/Agency/Other Entity
Johnny Callebs, Regional/Executive Director	Independent Opportunities- Richmond
Karen Gardner	Tri-Generations
Jan Eblen	Kentucky Association for Community Employment Services
Tracy Ruth	Kaleidoscope, Inc.
Marie Alagia Cull	Res-Care, Inc.
Shannon McCracken, Interim Executive Director	Kentucky Association of Private Providers
Brittany Knoth, Executive Director	Path Forward of KY
Robert J. Illback, Psy. D, ABPP, President and Chief Executive Officer	REACH of Louisville
Stephen S. Zaricki, MSW, Executive Director	Community Living, Inc.
David Coons	Family Home Provider
Meghen Wilson	Growing Minds Learning Center
Jenifer C. Frommeyer, Executive Director	Dreams with Wings
Leah F. Campbell, JD, Chief Operating Officer	Apple Patch Community
Tomika H. Cosby, Executive Director	Kentucky Case Management
Steve Frommeyer, Parent of a waiver services recipient	
Leigh Denniston	Almcare
Diane Quarles-Hartman, BS/MHA, Executive Director	Evergreen Life Services
Pamela J. Millay, RN, JD, Clinical Director/CPO	Redwood

Myra Gribbins, Owner/Executive Director	Reach for the Stars Case Management
Brad Schneider, Vice President, Developmental Services Division	LifeSkills, Inc.
Jodi Wilson, Regional Director	Rescare

(3) The following individuals from the promulgating agency responded to comments received regarding 907 KAR 12:020:

Name and Title	Organization/Agency/Other Entity
Claudia Johnson, Assistant Director	Division of Developmental and Intellectual Disabilities, Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID)
Alice Blackwell, Assistant Director	Division of Developmental and Intellectual Disabilities, Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID)
Earl Gresham, Assistant Director	Department for Medicaid Services, Division of Community Alternatives
Stuart Owen, Regulation Coordinator	Department for Medicaid Services, Commissioner's Office
Jonathan MacDonald, Internal Policy Analyst III	Department for Medicaid Services, Commissioner's Office

SUMMARY OF COMMENTS AND AGENCY'S RESPONSES

(1) Subject: Day Training

(a) Comment: Johnny Callebs, Regional/Executive Director, Independent Opportunities-Richmond, made the following comment:

"The Day Training upper payment limit of $2.20/unit is insufficient to provide community inclusion opportunities for individuals. The rate should be increased to at least $3.00/unit to help cover ever-increasing costs such as insurance, transportation, taxes, unemployment insurance, etc."

(b) Response: Thank you for your comments. No rate changes are being considered for the regulation at this time.

Even if the most conservative estimates place the average staff-to-participant ratio for adult day treatment at one staff member to five participants. With that ratio adult day training generates $48.40 per hour of service per staff member.

(a) Comment: Karen Gardner of Tri-Generations, made the following comment:

"Day Training is a service that most of us in this field would like to see decreasing instead of increasing but after decades in this field I think this service still holds a

valuable place in our service arena, not everyone wants a job and we have an aging population that needs to remain active but not necessarily employed. With adequate reimbursement Day Training can be a viable bridge for folks to the community. With adequate reimbursement we can provide one to one or small group opportunities in the community which can lead to community involvement and community inclusion.

Suggestion:

Day training rates need to be restored to a level that can support those who have no desire to have a job and for those who are aging and no longer desire employment. All persons deserve quality supports. One size does not fit all. Our waiver needs to be written to address and be flexible enough to serve the entire spectrum of folks we support."

(b) Response: Although the number of participants in day training has increased, when considering the overall increase in waiver participants and enrollment in day training, the percentage of waiver participants utilizing day training has decreased from 90% in 2013 to 87% in 2015.

The number of people utilizing community access is actually increasing – 294 people used this service in 2014 and 355 in 2015.

Since focusing on community employment the number of people with disabilities in Kentucky who are working in the community has risen from one of the lowest rates in the country to the national average of 18%.

(a) Comment: Jan Eblen of Kentucky Association for Community Employment Services, made the following comment:

"As part of the 2012 implementation of the new Supports for Community Living (SCL2) program by the Department for BHDIDD, the pay ment rate for Day Training was reduced from $10.00 to $8.80 per hour (a 12% decrease) and the rate for Supported Employment services was raised from $22.16 per hour to $41.00 per hour (an 85% increase). The apparent purpose of these rate adjustments was to increase the number of SCL participants who receive supported employment services.

Despite this effort it is apparent that participation in Supported Employment has remained largely stagnant since the implementation of the SCL2 Waiver. According to a recent Open Records Request to the Department for Medicaid Services, when comparing calendar year 2013 to 2014 the number of SCL participants receiving Supported Employment services increased only very slightly by 38 participants from 345 participants to 383. Also, when comparing Adult Day Training/ Day Training for the same period, the number of participants grew from 3,802 to 4,443, an increase of 641 participants. As a consequence, waiver recipients are increasing being served in underfunded, overcrowded day programs.

The reduced rate for Day Training services, poses a critical challenge for Kentucky as it seeks to comply the Center for Medicaid Services (CMS) recently published rules on Community Settings. Among CMS' expectations for non-residential settings are: the facilitation of sufficient opportunities to go into the broader community and to interact with the general public.

As Kentucky endeavors to implement the new CMS Community settings rule, Day Training service providers will no doubt find it most difficult to facilitate more opportunities for interaction with the general public and provide broader programmatic choice, as per CMS's new Community Settings Rule, as a consequence of the 12% rate cut.

Accordingly KACES respectfully requests that the rates for Day Training services be reconsidered/restored."

(b) Response: Although the number of participants in day training has increased, when considering the overall increase in waiver participants and enrollment in day training, the percentage of waiver participants utilizing day training has decreased from 90% in 2013 to 87% in 2015.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons, Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"Our 2013 comments said: KAPP strongly supports the development and pursuit of meaningful paid employment for participants, and increasing the opportunities for true integration into their community. However, providers are concerned that service choices are being limited and even eliminated in some cases. Day Training is the most widely utilized service in the waiver currently. Again, people who do not want to work or are of retirement age constitute a large segment of the SCL population, and could struggle with where they "fit" within the new service menu.

We addressed the negative effect of rate reduction in this way: The reduction of Day Training rate from $3 off site and $2.50 on site to a flat rate of $2.20 per unit may be intended to discourage this service option, that it COULD HAVE AN UNINTENDED EFFECT. Providers could resort to higher staff to participant ratios in order to manage

labor costs and other expenses. This would likely result in less intensive supervision and a decrease in quality of supports.

We take no satisfaction in having been right in this prediction. The real losers in this scenario have been the participants and the direct support staff in these overcrowded, understaffed and underfunded day centers, in which almost every person in the waiver, over 4,000 are at this very moment.

KAPP's request for the past 2 years has been to reinstate the Day Training rates. The majority of participants still need this service. Reducing the rate did not reduce the need, it reduced the quality. KAPP requests to work with the Cabinet to develop an appropriate adequately funded day training model that meets the criteria of the Final Rule moving forward.

Although NOT the intention of the waiver, on paper it appears to be a compliant and progressive regulation, Kentucky's resistance to remove barriers to the KEY services for a meaningful day and true community access has resulted in fewer choices. Additionally, the cut in the rates by 15% of those programs has resulted in lower quality, higher staff to participant ratios and fewer opportunities for community inclusion."

(b) Response: Although the number of participants in day training has increased, when considering the overall increase in waiver participants and enrollment in day training, the percentage of waiver participants utilizing day training has decreased from 90% in 2013 to 87% in 2015.

The number of people utilizing community access is actually increasing – 294 people used this service in 2014 and 355 in 2015.

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"The expectations for Day Training include: supporting the participation in daily, meaningful, routines of the community, which for adults may include work-like settings that do not meet the definition of SE. DT services stress training in the activities of daily living, self-advocacy, adaptive and social skills and are age and culturally appropriate.

The training, activities and routines established shall not be diversional in nature but rather, shall be meaningful to the person, shall provide an appropriate level of variation and interest, and shall assist the person to achieve personally chosen outcomes which are documented in the POC. These services can be provided at a fixed location or in community settings. The hours must be spent in training and program activities and must be based on each individual's Plan of Care. In addition, Day Training may include involvement in community-based activities that assist the person in increasing his/her ability to access community resources and being involved with other members of the general population.

The costs of running a quality day training center, if that was the only service you chose to provide could only be covered at about a 10:1 ratio, at best. In order to meet the expectation for this service, the rates must either reflect the ability to provide 1:1 or 1:2 service to participants who ALL deserve it or remove the barriers to Community Access which have been identified and make it a service everyone can provide and receive."

(b) Response: The hourly rate for day training is a per person rate. Day training is not a one on one service. An agency may support any number of participants in a day setting. If as you state a 10:1 ratio is used, using the current day training rate of $2.20 per 15 minute unit, the amount billed per hour would be $88.00.

Community access is available to all waiver participants. It is not necessarily expected that a participant would achieve total independence within a natural setting within six months; however, within the six month prior authorized period concrete objectives specified in the plan should have been accomplished. If additional supports are needed to advance the person's ultimate outcome, they may be requested through a plan modification.

The expectation is that careful and deliberate person centered planning will result in supports that will result in customized supports tailored to the specific needs and desires of the person involved. This will vary immensely from person to person and may include paid or unpaid supports.

Community access services are designed to enable people to have increased access to community resources and offer opportunities for people to develop personal social networks by building friendships and making connections with other people in their local communities. Impact services, such as community access, are expected to have a significant effect on a person's ability to engage with other people in the local community. Prior authorizations for this service are limited to up to 6 months per request; however, should the person require ongoing community access service beyond a six month prior authorization, the person centered team may request ongoing services based on the person's ongoing need for assistance to connect with community members. The service provision should decrease as the person develops the skills needed to maintain the connection within the community. Other Supports for Community Living (SCL) services, such as day training and residential services should be utilized, if needed, when community access services are withdrawn, to assist the

person with any additional needs, such as personal care, financial management or transportation.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons, Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“There are over 4,000 waiver recipients still utilizing the Day Training Service. It is a wanted and needed service, but one that could be much higher quality and more community based with the appropriate funding. The waiver application, based upon trend, predicts there will still be over 4,000 people in Day Training centers 5 years from now.

For Kentucky to sincerely comply AND succeed with the CMS Rule in the next 4 years, the barriers to true Community Access and quality Day Training centers, for everyone must be removed.”

(b) Response: Although the number of participants in day training has increased, when considering the overall increase in waiver participants and enrollment in day training, the percentage of waiver participants utilizing day training has decreased from 90% in 2013 to 87% in 2015.

The number of people utilizing community access is actually increasing – 294 people used this service in 2014 and 355 in 2015.

Since focusing on community employment the number of people with disabilities in Kentucky who are working in the community has risen from one of the lowest rates in the country to the national average of 18%.

In addition, the stated goal for increasing the employment of SCL2 participants canvassed through the National Core Indicators was to increase the number of participants working in the community by 5%. After accounting for uniform (5%) job losses across both Kentucky and the entire nation caused by the economic recession, Kentucky has rebounded to record the targeted 5% increase in the community employment of SCL participants from the post-recession low (2013/14 data).

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons, Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"Day Training is a service that most providers would like to see decreasing instead of increasing. After decades of experience in the field, providers believe this service still holds a valuable place in the service arena. Not every person wants a job and we have an aging population that needs to remain active but not necessarily employed. With adequate reimbursement Day Training can be a viable bridge to the community. With adequate reimbursement we can provide one to one or small group opportunities in the community, which would lead to community involvement and inclusion, as the CMS Final Rule intends.

KAPP requests that day training rates be restored to a level that can support those who have no desire to have a job and for those who are aging and no longer desire employment. All persons deserve quality supports. One size does not fit all. Our waiver needs to be written to address everyone's needs and be flexible enough to serve the entire spectrum of people we support."

(b) Response: Although the number of participants in day training has increased, when considering the overall increase in waiver participants and enrollment in day training, the percentage of waiver participants utilizing day training has decreased from 90% in 2013 to 87% in 2015. The number of people utilizing community access is actually increasing – 294 people used this service in 2014 and 355 in 2015.

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"Day Training SCL 1 rates were $12 for community based and $10 for onsite/per hour. Prior to SCL2, many providers conducted DT activities in the community. For a program that conducted 2/3 of the training activities off-site, the actual reduction would be 27.5%. Both rates were reduced to $8.80/hour. The inevitable result has been reductions in staffing, charging individuals for activities fees, and in some instances program closures. The most devastating result has been the need to curtail community activities. The net effect was completely antithetical to the desire for greater community involvement, just as providers warned at the time the regulation was written. At the current and proposed levels, Day Training is an overused, overcrowded model that is unsustainable.

The rate reduction in Day Training was justified in the waiver (which guaranteed that no individual would lose services) and to the provider community with the assurance that Community Access would be available to all and would be a viable alternative means to fund community based training activities. That has not happened and it never will, so in reality people are losing services and Kentucky is on a path of failing to comply with the CMS Final Rule."

(b) Response: Community access is available to all waiver participants. It is not necessarily expected that a participant would achieve total independence within a natural setting within 6 months. However, within the six month prior authorized period, concrete objectives specified in the plan should have been accomplished. If additional supports are needed to advance the person's ultimate outcome, they may be requested through a plan modification.

The expectation is that careful and deliberate person centered planning will result in supports that will result in customized supports tailored to the specific needs and desires of the person involved. This will vary immensely from person to person and may include paid or unpaid supports.

Community access services are designed to enable people to have increased access to community resources and offer opportunities for people to develop personal social

networks by building friendships and making connections with other people in their local communities. Impact services, such as community access, are expected to have a significant effect on a person's ability to engage with other people in the local community. Prior authorizations for this service are limited to up to 6 months per request; however, should the person require ongoing community access service beyond a six month prior authorization, the person centered team may request ongoing services based on the person's ongoing need for assistance to connect with community members. The service provision should decrease as the person develops the skills needed to maintain the connection within the community. Other SCL services, such as day training and residential services should be utilized, if needed, when Community Access services are withdrawn, to assist the person with any additional needs, such as personal care, financial management or transportation.

(a) Comment: Jodi Wilson, Regional Director, Rescare, made the following comment:

"I find great issue with regulation as it relates to Day Training services and the reduction in the rates for those services. The path Kentucky is on eliminates the chance for those who are most challenged by their disability(ies) to gain much needed training in a world that understands and supports them best. I agree the nature of Day Training needs to change in order to improve the quality of individual lives and services; however, to do this funding is required. Requirements can and should be changed to incorporate more training and community integration with financial supports for staffing and vehicles to help support folks to have the life they have envisioned."

(b) Response: Thank you for your comments. The Cabinet has already delayed the day training reduction by a year and a half.

(2) Subject: Consultative Clinical & Therapeutic Services / Positive Behavior Supports

(a) Comment: Johnny Callebs, Regional/Executive Director, Independent Opportunities-Richmond, made the following comment:

"Consultative clinical and therapeutic services has an annual limit of 160 units per plan year. This does not begin to cover the needs of participants with extreme behavioral needs. Please consider increasing the limit."

(b) Response: Units required above the 160 limit may be requested through exceptional supports. The intent of these changes was to put more focus on an integrated person centered team which includes participation by all service providers. Kentucky is fortunate to have exceptional supports available when extraordinary circumstances related to the assessed needs of a person are indicated. The information that is requested by the department has demonstrated the capability of identifying extraordinarily high levels of support needs which has resulted in a 71.87% approval rate. The department recognizes the efforts that are put forth on behalf of the citizens. Partners in the provider community should be commended for the professional manner in which they gathered and organized information which allows for dialogue, focused

planning, and a clear path of interventions that is witnessed in the improvement of the citizens' daily lives. In fact, to date, the data shows that 82% of the persons approved for exceptional supports did not have additional requests for supports. The exceptional support needs identified through the robust assessment process meet a specific intent. These supports would not become an indefinite part of a person's support plan; however, these supports may come and go throughout a person's life on an as-needed basis. The data strongly suggests that this is occurring.

SCL2 placed a limit on the benefit for consultative clinical and therapeutic services to 160 units per year. We are challenged with providing quality support with finite resources to waiver recipients. The 160 units per year are not a mandatory end of these supports. If supports are needed and necessary, Exceptional support requests can be submitted. From January 1, 2014, through September 28, 2015, claims data would suggest an average number (1,666) of persons received consultative clinical and therapeutic services in SCL 2. Of this number, the department received and approved 35 unique requests for consultative clinical and therapeutic services when the services were exhausted. In addition, the department received another 22 requests for consultative clinical and therapeutic services which were denied. The primary reason for 90% of these denials is because the SCL2I Benefits for consultative clinical and therapeutic services were found to be sufficient to meet the needs of the person. The team was asked to resubmit if, and when, the unit limit would be exhausted in 30 days. As such, we have 37 unique requests for exceptional supports from a potential of 1,666. Partners in the community have stepped up and focused their attention and efforts to provide quality supports within the limits of SCL2.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons, Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"In 2013 KAPP was greatly concerned over the rate and unit reductions for behavior support services. It seemed to be in contradiction to the Employment First mission of the waiver itself. Behavioral and Psychological supports can be an effective and essential tool in supporting a participant's success in the community and especially in employment. The overall reduced rates and caps on units effectively deny individuals in the SCL program with the most severe behaviors and mental health issues from accessing the services they need to address their health, safety and welfare and allow

them to be part of the greater community. This will result in an increased to themselves, peers, staff and community members, leading to more frequent crisis situations. There would likely be increased involvement with law enforcement, placement in psychiatric facilities, and increased medication administration, which will decrease the quality of the participant's lives and offset any monetary savings from slashing these services.

The reality for providers and participants today: The reductions in units for Behavior and Psychological support have resulted in even greater challenges to obtaining quality behavior support services. The Behavior Crisis system for people in community services does not provide agencies with crisis supports other than through meetings and phone calls. There is no on-site assistance, which at times as resulted in police involvement and even hospitalizations since no other resources have been available to assist. The Exceptional Rate Protocol was the answer to every worry and concern we had back in 2013. That process has not been the effective solution and certainly not a guaranteed or a timely one. We will address that in a later section in more detail.

KAPP's recommendation for the past 2 years has been: Restore units for Behavior Supports and Psychological. Behavior IS a major barrier to community integration and employment."

(b) Response: Units required above the 160 limit may be requested through exceptional supports. The intent of these changes was to put more focus on an integrated person centered team which includes participation by all service providers. Kentucky is fortunate to have exceptional supports available when extraordinary circumstances related to the assessed needs of a person are indicated. The information that is requested by the department has demonstrated the capability of identifying extraordinarily high levels of support needs which has resulted in a 71.87% approval rate. The department recognizes the efforts that are put forth on behalf of the citizens. Partners in the provider community should be commended for the professional manner in which they gathered and organized information which allows for dialogue, focused planning, and a clear path of interventions that is witnessed in the improvement of the citizens' daily lives. In fact, to date, the data shows that 82% of the persons approved for exceptional supports did not have additional requests for supports. The exceptional support needs identified through the robust assessment process meet a specific intent. These supports would not become an indefinite part of a person's support plan; however, these supports may come and go throughout a person's life on an as-needed basis. The data strongly suggests that this is occurring. The SCL2 placed a limit on the benefit for consultative clinical and therapeutic services to 160 units per year. We are challenged with providing quality support with finite resources to waiver recipients. The 160 units per year are not a mandatory end of these supports. If supports are needed and necessary, exceptional support requests can be submitted. From January 1, 2014, through September 28, 2015, claims data would suggest an average number (1,666) of persons received consultative clinical and therapeutic services in SCL 2. Of this number, the department received and approved 35 unique requests for consultative clinical and therapeutic services when the services were exhausted. In addition, the department received another 22 requests for consultative clinical and therapeutic

services which were denied. The primary reason for 90% of these denials is because the SCL2 benefits for consultative clinical and therapeutic services were found to be sufficient to meet the needs of the person. The team was asked to resubmit if, and when, the unit limit would be exhausted in 30 days. As such, we have 37 unique requests for exceptional supports from a potential of 1,666. Partners in the community have stepped up and focused their attention and efforts to provide quality supports within the limits of SCL2.

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“Recommend that monies allocated for Speech, Occupational and Physical therapies, which were removed from the waiver, be added to increasing the limit of Consultative & Clinical Therapies from 160 units per year to 240 units per year (average of 20 units per month.) This change would reduce the number of exceptional support requests.”

(b) Response: DMS is not reducing coverage of therapies as waiver participants who previously/currently receive them as a waiver program benefit will be able to receive them as a state plan benefit. Thus, though DMS expenditures on therapies as a waiver benefit will drop DMS expenditures on therapies as a state plan benefit will increase proportionately.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons, Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“Consultative Clinical and Therapeutic Services have an annual limit of 160 units per plan year. This does not begin to cover the needs of participants with extreme behavioral needs. Please consider increasing the limit. Recommend that units be restored to SCL 1 levels. Behavior IS a major barrier to community integration and employment.”

(b) Response: Units required above the 160 limit may be requested through exceptional supports. The intent of these changes was to put more focus on an integrated person centered team which includes participation by all service providers. Kentucky is fortunate to have exceptional supports available when extraordinary circumstances related to the assessed needs of a person are indicated. The information that is requested by the department has demonstrated the capability of identifying extraordinarily high levels of support needs which has resulted in a 71.87% approval rate. The department recognizes the efforts that are put forth on behalf of the citizens. Partners in the provider community should be commended for the professional manner in which they gathered and organized information which allows for dialogue, focused planning, and a clear path of interventions that is witnessed in the improvement of the citizens’ daily lives. In fact, to date, the data shows that 82% of the persons approved for exceptional supports did not have additional requests for supports. The exceptional support needs identified through the robust assessment process meet a specific intent. These supports would not become an indefinite part of a person’s support plan; however, these supports may come and go throughout a person’s life on an as-needed basis. The data strongly suggests that this is occurring. The SCL2 placed a limit on the benefit for consultative clinical and therapeutic services to 160 units per year. We are challenged with providing quality support with finite resources to waiver recipients. The 160 units per year are not a mandatory end of these supports. If supports are needed and necessary, exceptional support requests can be submitted. From January 1, 2014, through September 28, 2015, claims data would suggest an average number (1,666) of persons received consultative clinical and therapeutic services in SCL 2. Of this number, the department received and approved 35 unique requests for consultative clinical and therapeutic services when the services were exhausted. In addition, the department received another 22 requests for consultative clinical and therapeutic services which were denied. The primary reason for 90% of these denials is because the SCL2 benefits for consultative clinical and therapeutic services were found to be sufficient to meet the needs of the person. The team was asked to resubmit if, and when, the unit limit would be exhausted in 30 days. As such, we have 37 unique requests for exceptional supports from a potential of 1,666. Partners in the community have stepped up and focused their attention and efforts to provide quality supports within the limits of SCL2.

(3) Subject: Exceptional Supports

(a) Comment: Johnny Callebs, Regional/Executive Director, Independent Opportunities-Richmond, made the following comment:

“The process of getting approval for exceptional supports isn’t clear. Most providers have their requests denied. The process is laborious and lengthy. There is no provision for emergency approval and the crisis at hand usually worsens while waiting for an answer on the exceptional support request. Only select services are eligible for exceptional support. All should be, including case management which can require time and resources far beyond what is typically needed to coordinate care for an individual.

The Kentucky Exceptional Supports Protocol: 6. a Documentation of completion of the expanded requirements for direct support professional (DSP) as appropriate. What does this mean?
6. b. Documentation of the provider’s ability to support people with exceptional behavioral health or behavioral support needs ….. Does this mean that if the provider does not have a lot of experience in behavior supports the exceptional support request will not be approved?”

(b) Response: To date this has not been identified as a barrier and has not been a factor in any denial for behavioral supports. The documentation of completion of the expanded requirements for direct support professional (DSP) is relevant if an agency identifies the need for more specially trained DSPs in order to provide support to the participant. If this is the case, that information should be included in the exceptional support request.

(a) Comment: Marie Alagia Cull of Res-Care, Inc., made the following comment:

“The exceptional support service is designed to provide additional funding in an extraordinary circumstance in excess of the upper limit for the service for a specified amount of time and to meet the assessed needs of the participant. 907 KAR 12:020(1)(4). Section 4 of the regulation establishes the requirements to qualify for exceptional support services and payments. ResCare has 11 local SCL providers across the Commonwealth which have supported up to 81 clients with one- to-one staffing/supervision since the exceptional supports funding was initiated. Some of our clients require two-to-one staffing at times. Almost all requests for exceptional supports have been denied often because the supports were already in place when the request was made. In some cases, the case managers have failed to complete the applications because of the burden of the application and the almost certain denial. ResCare continues to provide the additional services and supports even though it receives no additional payment. In those situations where exceptional supports were approved, the six month time limit has repeatedly proved to be both inadequate and inappropriate to meet the person's need for supports. The six month term is arbitrary, inflexible and unrealistic because most of the clients who require the additional supervision and support have chronic psychiatric, behavioral, or medical conditions that are not resolvable within six months. ResCare's agencies, (Community Alternatives Kentucky) support people with uncontrolled seizures, unresolved with medications and Vagus Nerve Stimulator ("VNS") and other significant physical problems that require additional supports to ensure health, safety and welfare. The lack of quality behavior supports and effective crisis management supports fail to provide a strategy for long term behavioral

change. Strict time limits, such as six months, fail to recognize that individuals with intellectual disabilities often have long term conditions that cannot be remediated.

ResCare suggests the Cabinet develop a person-centric reimbursement system. Some states have adopted a tiered payment system while others allocate units of service based on an individual's need."

(b) Response: Thank you for your comments and suggestion. DMS is not adopting the recommendation at this time, but will consider it when next renewing the waiver.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons, Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"KAPP's comments in 2013 on the Exceptional Rate Protocol were minimal, as we were assured time again that this would be the answer for any limit caps, rate reductions, discontinuation of the NC Snap High Intensity funding for some participants, etc. It was an untested process and we had no choice but to see how it worked out. Our one comment was this: *KAPP requests a clarification on the specific process for request and approval.*

In reality, the process has been confusing and frustrating at best.

While it is acknowledged that the Exceptional Rate Protocol may be an attempt to rectify this problem, it is a fundamentally flawed approach. For example, the Exceptional Rate approval process is time-consuming and complicated and there is no process for emergency approvals. It requires that any proposal that is submitted be to fund new, time-limited initiatives and cannot be used to provide necessary supports (e.g. 1:1 staff support) that have already been put into place for health or safety reasons. Many people experience behavior, mental health or medical crises, necessitating the provision of intensified supports in order to keep them safe and in many cases, these services are required for long periods of time. The proposed protocol does not take these situations into account so it fails to solve the problem of cost of service inequity. In addition, neither the reimbursement structure nor the Exceptional Rate Protocol take into account the fact that the population served is aging, leading to increased costs, trending upwards over time. In short, the proposed regulation is at best a short-term fix, when a

long-term approach is warranted. Kentucky's disabled population would be better served if an entirely new rate structure – tied to individual support needs – were implemented in place of the Exceptional Rate Protocol.

We've been told the Exceptional Rate Fund has no budget. Do the funds come from future slot allocations, the ones that are approved?

We are often told to call the Comp Cares for crisis supports before requesting Exceptional Rates. Our understanding is that those monies are from the State General Fund, as well…the same pot as the Exceptional Rate money?

Many participants in need of additional supports and funding (LONG TERM) were people who successfully transition out of ICF's through Money Follows the Person. Many of those participants were considered difficult to support in that setting at 4-5 times the reimbursement rates. Now we are serving them in the community at reduced rates, service unit caps and with a difficult if not impossible way to get support to keep them safe and in their community.

Participants in crisis can end up in prison, homeless shelters, court ordered out of their homes and communities, before Exceptional Supports can be secured in some cases. To add insult to injury, when searching for new service providers for these participants, often no one is willing to take a chance on the person because they don't want to inherit this difficult situation.

It should be noted that the Exceptional Rate request process lies in the hands of the case managers. Yes, this is part of their job, but it is difficult, time consuming and they are not incentivized to ensure the process occurs. Case Management spends additional hours and days on these cases and has no opportunity for enhanced rate for those services.

There should be a process for emergency approval. The approval should backdate to the request to ensure service occurs when needed. This is something the person centered team and conflict-free case manager should decide and monitor responsibly. With the discontinuation of both the enhanced rate for participants assessed as high-intensity (in SCL 1) and the Money Follows the Person waiver, the Exceptional Rate Protocol was the promise to providers for the continued safe support of participants with exceptional needs (medical, behavioral, etc.) This promise has not been fulfilled. Providers are told there is no budget for this and the request process is laborious and difficult. The waiver application predicted (based upon data) that approximately 8% of the waiver population would need Exceptional Rate supports, however only 3-4% have been approved for it. The protocol has no "protocol". Support teams need a clearly defined process for what is appropriate to request, how to request it and a timely process for approval."

(b) Response: The request for exceptional supports is either for unit rate increase or unit increase. The goal of the exceptional support team is to deliver a resolution within 14

business days. In reviewing the data and calculating turnaround time in both business days and calendar days our data does show the average business days as 10.3 days and the average calendar days as 13.07. The total number of service requests was 302 (89% of all service requests). To be able to reach a decision the information that was submitted was responsive and further documentation was not necessary. A second group of requests, which totaled 36 (11% service requests), did need additional information before a decision was made as the information was incomplete and non-responsive. When the information that was requested was received the average business days turnaround time was 3.89 days while the average calendar days was 3.94 days. 89% of the service requests would indicate a clear understanding of the exceptional supports protocol. With our average turnaround time, the system is set up to result in no service gaps. This is well seen in the 89% of the service requests when partners in the provider community provide responsive and complete information for review. The data would suggest that with this support the system in place is an emergency oriented culture.

Kentucky is fortunate to have exceptional supports available when extraordinary circumstances related to the assessed needs of a person are indicated. The information that is requested by the department has demonstrated the capability of identifying extraordinarily high levels of support needs which has resulted in a 71.87% approval rate. The department recognizes the efforts that are put forth on behalf of citizens. The provider community should be commended for the professional manner in which they gathered and organized information which allows for dialogue, focused planning, and a clear path of interventions that is witnessed in the improvement of peoples' daily lives. In fact, to date, the data shows that 82% of the persons approved for exceptional supports did not have additional requests for supports. The exceptional support needs identified through the robust assessment process meet a specific intent. These supports would not become an indefinite part of a person's support plan; however, these supports may come and go throughout a person's life on an as-needed basis. The data strongly suggests that this is occurring.

We presently have 4650 persons enrolled in the SCL program. The exceptional support committee has issued 160 decisions which reflect 3.4% of the population was identified as potentially needing exceptional supports. The prime driver of recognizing possible situations where exceptional supports might be necessary come from the network providers. The data would suggest that the providers only identified a total of 3.4% of the population in need of exceptional support review. It is also outstanding that 89% of the service requests were submitted without any problems and were clearly in compliance with what was needed to make a decision.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.;
David Coons, Family Home Provider; Meghen Wilson Growing Minds Learning Center;
Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD,

Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“The process of getting approval for exceptional supports is not clear. Many providers have their requests denied. The process is laborious and lengthy. There is no provision for emergency approval and the crisis at hand usually worsens while waiting for an answer on the exceptional support request. Only select services are eligible for exceptional support. All should be, including case management, which can require time and resources far beyond what is typically needed to coordinate care for a participant.

The Kentucky Exceptional Supports Protocol: 6.a. Documentation of completion of the expanded requirements for direct support professional (DSP) as appropriate. What does this mean?

6.b. Documentation of the provider’s ability to support people with exceptional behavioral health or behavioral support needs. Does this mean that if the provider does not have a lot of experience in behavior supports the exceptional support request will not be approved?”

(b) Response: To date this has not been identified as a barrier and has not been a factor in any denial for behavioral supports. The documentation of completion of the expanded requirements for direct support professional (DSP) is relevant if an agency identifies the need for more specially trained DSPs in order to provide support to the participant. If this is the case, that information should be included in the exceptional support request.

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“There should be a process for emergency approval. The approval should backdate to

the request to ensure service occurs when needed. Again, this is something the person centered team and conflict-free case manager should decide and monitor responsibly. Projected 8% of population would need it based upon data; only 3-4% participants have been approved for it."

(b) Response: The request for exceptional supports is either for unit rate increase or unit increase. The goal of the exceptional support team is to deliver a resolution within 14 business days. In reviewing the data and calculating turnaround time in both business days and calendar days our data does show the average business days as 10.3 days and the average calendar days as 13.07. The total number of service requests was 302 (89% of all service requests). To be able to reach a decision the information that was submitted was responsive and further documentation was not necessary.

A second group of requests, which totaled 36 (11% service requests), did need additional information before a decision was made as the information was incomplete and non-responsive. When the information that was requested was received the average business days turnaround time was 3.89 days while the average calendar days was 3.94 days.

89% of the service requests would indicate a clear understanding of the exceptional supports protocol. With our average turnaround time, the system is set up to result in no service gaps. This is well seen in the 89% of the service requests when partners in the provider community provide responsive and complete information for review. The data would suggest that with this support the system in place is an emergency oriented culture.

Kentucky is fortunate to have exceptional supports available when extraordinary circumstances related to the assessed needs of a person are indicated. The information that is requested by the department has demonstrated the capability of identifying extraordinarily high levels of support needs which has resulted in a 71.87% approval rate. The department recognizes the efforts that are put forth on behalf of citizens. The provider community should be commended for the professional manner in which they gathered and organized information which allows for dialogue, focused planning, and a clear path of interventions that is witnessed in the improvement of peoples' daily lives. In fact, to date, the data shows that 82% of the persons approved for exceptional supports did not have additional requests for supports. The exceptional support needs identified through the robust assessment process meet a specific intent. These supports would not become an indefinite part of a person's support plan; however, these supports may come and go throughout a person's life on an as-needed basis. The data strongly suggests that this is occurring.

We presently have 4650 persons enrolled in the SCL program. The exceptional support committee has issued 160 decisions which reflect 3.4% of the population was identified as potentially needing exceptional supports. The prime driver of recognizing possible situations where exceptional supports might be necessary come from the network providers. The data would suggest that the providers only identified a total of 3.4% of

the population in need of exceptional support review. It is also outstanding that 89% of the service requests were submitted without any problems and were clearly in compliance with what was needed to make a decision.

(4) Subject: Reimbursement and Limits

(a) Comment: Karen Gardner of Tri-Generations, made the following comment:

“Providers are dealing with increased administrative requirements that have hefty price tags, increased costs of utilities, food, property and liability insurance and staff costs such as pay increases, health insurance, and the increased costs of life in general. There must be discussion about the current rates especially in light of the increased scrutiny and requirements that are coming with the CMS Final Rule.

Suggestion:

We need increased rates, we can’t keep absorbing costs.”

(b) Response: Thank you for your comments. No rate changes are being considered for the regulation at this time.

(5) Subject: Therapies

(a) Comment: Tracy Ruth of Kaleidoscope, Inc., made the following comment:

“First, let me say that we applaud the Cabinet’s decision to finally expand access to occupational, physical and speech therapy services to individuals in the traditional Medicaid program. We believe that this decision will save Medicaid money by keeping people out of the hospital, preventing surgeries and creating a more productive population. However, treating the traditional Medicaid population and those in the waiver programs the same will cause multiple problems for the waiver participants.

Currently, hundreds of occupational, physical and speech therapists around the Commonwealth are providing services to the intellectually and developmentally disabled population in the waiver programs. Most provide those services through contracts with larger entities like Seven Counties, Cedar Lake and Dreams with Wings where these larger entities bill Medicaid for the service.

We believe that this proposed change would create a significant shortage in therapy providers available to provide services because the individual therapists will be required to obtain their own Medicaid number and bill directly. There are two main problems with this change and both result in reduced access to care.

First, there are OTs, PTs and SLPs currently enrolled as Medicaid providers who are billing for their services but most of them are treating Medicaid’s traditional population for injury-related occurrences and do not provide therapies unique to the waiver

population. Most therapists providing services to the waiver population do not have their own Medicaid number. We have heard from some therapists who have been going through that process for a year and still don't have their number."

(b) Response: Thank you for your comment. For the most recently completed state fiscal year (which ended June 30, 2015) the average length of time to process and complete a provider's enrollment in the Medicaid Program was 56 days. Applications that contained errors or were incomplete take longer; thus, DMS encourages applicants to make sure that they complete the application in entirety and provide the required documentation.

The cabinet is actively working on a therapy transition plan with the Centers for Medicare and Medicaid Services (CMS) to assure that waiver participants will not lose their services and to attempt to close the gap in the payment rates between the state plan and the waiver.

(a) Comment: Tracy Ruth of Kaleidoscope, Inc., made the following comment:

"In addition to it taking many months to obtain a Medicaid number, we have recently learned that most of these practitioners will be required to get a Certificate of Need. Most therapists who work with this population are small practices that are owned by an OT or PT or SLP and employ therapists of the other disciplines. This requires a Certificate of Need. These small businesses don't have the financial ability to go through the lengthy and expensive CON process. We are being told by most that they will have to stop providing services. Even if they could afford to go through the CON process, who is going to serve this vulnerable population while they work to get their CON and Medicaid number?"

(b) Response: Thank you for your comment. Individual providers who enroll as a therapist will not need a certificate of need. The cabinet is actively working on a therapy transition plan with CMS to assure that waiver participants will not lose their services.

(a) Comment: Tracy Ruth of Kaleidoscope, Inc., made the following comment:

"The second obstacle for us is the reimbursement. Yes, reimbursement for therapy services under the waiver program is slightly higher than traditional Medicaid, but that makes sense. Working with a person with intellectual and developmental disabilities is more labor intensive than working with a person to rehabilitate them after an injury or a stroke. If the reimbursement is too low, we definitely cannot afford to go through all the costs associated with becoming a Medicaid provider and provide the services.

What do we want? We want to be able to continue serving our patients because these particular therapists are the most qualified in their field to treat this unique population. There will be a devastating impact on these individuals if their therapists can no longer afford to provide the service."

(b) Response: Thank you for your comment. The Cabinet is actively working on a therapy transition plan with CMS to assure that waiver participants will not lose their services and to attempt to close the gap in the payment rates between the state plan and the waiver.

(6) Subject: Overall Issues with the SCL Waiver

(a) Comment: Marie Alagia Cull of Res-Care, Inc., made the following comment:

“ResCare is a Kentucky based corporation that has been providing services to individuals with intellectual disabilities in Kentucky since 1978 when it started with Higgins Learning Center in Morganfield, Kentucky. ResCare is the largest private provider of services to persons with disabilities in the United States, as well as in Kentucky. ResCare Residential Services serves approximately 18,000 people in 28 states, with approximately 900 of those individuals living in Kentucky.

Medicaid waiver services, including Kentucky's Supports for Community Living Program (''SCL Program''), are designed to enable individuals who would otherwise be institutionalized to remain in their homes in their communities. The overall objective of the SCL Program is to provide the appropriate and necessary supports for individuals to achieve and maintain their highest level of independence. The SCL Program model has actually decreased the cost of care for many individuals living in the community with the goal of improving their overall quality of life. In Kentucky, the SCL waiver program falls short of this goal. ResCare fully embraces the SCL waiver and works to ensure the goals of the program are achieved by the people we serve.

ResCare supports the comments and suggestions submitted by the Kentucky Association of Private Providers.

Kentucky's current SCL regulations impose costly and burdensome requirements on Kentucky's network of private service providers. In all of the states in which ResCare Residential Services operates, Kentucky has the most challenging regulatory environment.”

(b) Response: Thank you for expressing your concerns and comments.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons, Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO

Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"The Kentucky Association of Private Providers (KAPP) currently has 74 provider members and 6 associate members. This is the largest membership of KAPP's 33- year existence, representing a blend of non-profit and for-profit providers, ranging from the Commonwealth's smallest to largest service provider agencies. We are currently conducting a demographic study, but at last count KAPP members provided support for over 75% of all waiver recipients in Kentucky. Please find our comments on the SCL waiver regulation, which address not only the most current revisions, but also other serious problems and barriers throughout the entire regulation, which we first identified and submitted comment on prior to the initial implementation.

In 2013, KAPP testified at a public hearing for this Supports for Community Living waiver prior to its implementation. At that time we expressed our considerable concern, as professionals in this field with decades of experience providing quality supports to Kentucky's citizens with I/DD.

The Commissioner of DBHDID at that time, Stephen Hall, promised in an email to providers that he had "listened to people with disabilities of all ages, their family members, those who are paid with taxpayer dollars to provide services and those who advocate to improve Kentucky's individualized supports." He went on to say that we want "these most vulnerable citizens to have good evidenced based services to improve their lives." He concluded this email by saying, "while not perfect, this can be a giant step forward for Kentucky citizens with developmental and intellectual disabilities and their families."

KAPP believes that was a sincere message and we do support the mission and intent of the waiver, as well as the CMS Final Rule, ADA and Olmstead Act. That being said, providers do NOT feel that we've been heard. We predicted in 2013 the specific reasons why the waiver contained insurmountable barriers to success for participants. Since that time, we have offered suggestions and solutions on a regular basis, which we believe would bring us to a successful outcome. We are not talking about success for providers; we are talking about success for the participants who utilize the waiver. The Department may believe that the failure of the waiver thus far is due to providers' resistance to change. Although any change in the way services are delivered is a challenge, providers have always adapted and risen to the occasion. The reality is, agencies would not refuse to assist participants into needed services. If the assumption were that providers are only concerned with funding, why would we not access the HIGH RATES for the service of Supported Employment and Community Access, and GROW the underfunded, overcrowded and understaffed Day Training model? The only reasonable answer for the condition of the SCL waiver today is that it does not work. We have been offering solutions since 2013 and continue to do so. The barriers to services and the excessive administrative burdens must be removed.

KAPP believes providers have NOT been true stakeholders in the development of the State Transition Plan, which is required by CMS for compliance with the Final Rule. Kentucky conducted the required forums, but the DBHDID's Quality Assurance staff (which is the entity with direct contact to and providing technical assistance for providers) has not been educated on the rule and could not answer questions or provide guidance on the self---assessment process agencies were issued. The surveys were sent out without an explanation of their significance. Assuming it was another required survey from the division, many Executive Directors delegated the task to program directors or other staff to complete. They did not realize that this would result in their initial classification in the CMS Final Rule process. The majority of providers were classified as NOT being Home & Community Based and subject to the heightened scrutiny process. This was surprising and unsettling for providers. Providers were then given another survey opportunity and have been told these results could change their classifications. Providers anxiously await those results. The lack of information and collaboration between the state and providers has caused fear and skepticism about the entire process. The only source of information for providers on the CMS Final Rule is an email address at ky.gov.

When KAPP has requested information or even a copy of the CMIA letter issued to Kentucky, we received no response. We have found the needed information either from ANCOR or directly from CMS through its website. KAPP requests that Kentucky immediately begin involving and informing providers (and its DBHDID Quality Assurance staff) in order to work together and successfully comply with the Home & Community Based Rule by the required timelines. This process is about the participants we support in the community. Kentucky cannot implement effective change without supporting its provider community to do so.

As for this specific regulation, there have been some modifications since the original draft in 2013 and we appreciate that, however, the top 10 changes we have discussed and advocated for over 2 years, have not been seriously addressed. With the CMS Final Rule now very much a daunting reality for all of us, the success for Kentucky and its citizens with I/DD rides on the future of this waiver.

Throughout KAPP's comments, I will be referencing our original comment in 2013, our proposed solution, what did change and our comment for this specific proposed regulation."

(b) Response: Thank you for your comment. Prior to the submission of the Statewide Transition Plan to CMS, there was a 30-day public comment period, beginning on November 5, 2014. During this time, providers, participants, and advocacy groups were welcome to submit their comments on Kentucky's process for coming into compliance with the HCBS federal final rules. Many stakeholders did, in fact, provide comments at that time. The Cabinet will be communicating updated compliance categories to providers based on their submitted compliance plan templates in November.

(7) Subject: Person-Centered Services

(a) Comment: Marie Alagia Cull for Res-Care, Inc., made the following comment:

“Both 907 KAR 12:010 and 907 KAR 12:020 repeatedly reference "person-centered services," yet the current rate structure and provider reimbursement system is anything but person-centered. It is a "one rate fits all" structured program funding slots rather than funding individuals receiving services. Costs associated with supporting some individuals are far less than others who have more severe issues and disabilities. The current reimbursement structure and its effort to address certain situations through the exceptional rate protocol fail to acknowledge that the population is aging and the costs are trending upwards. An entirely new rate structure tied to individual support needs is necessary to address the sustainability of the waiver program. This rate should be fair and flexible to meet the needs of the person using the service without impeding the provider's ability to serve the individual's needs. The reimbursement system should acknowledge that many individuals with severe and profound intellectual disabilities have lifelong barriers that require a lifetime of support services, sometimes intensive. It also fails to address the extremely unique challenges of supporting people with significant behavioral issues or dual diagnoses that require more than six months of additional services to meet their needs.”

(b) Response: Kentucky is fortunate to have exceptional supports available when extraordinary circumstances related to the assessed needs of a citizen are indicated. The information that is requested by the department has demonstrated the capability of identifying extraordinarily high levels of support needs which has resulted in a 71.87% approval rate. The department recognizes the efforts that are put forth on behalf of the citizens. Partners in the provider community should be commended for the professional manner in which they gathered and organized information which allows for dialogue, focused planning, and a clear path of interventions that is witnessed in the improvement of people’s daily lives. In fact, to date, the data shows that 82% of the persons approved for exceptional supports did not have additional requests for supports. The remaining 18% of the persons approved for exceptional supports have received additional exceptional supports beyond their original approval. This was accomplished due to again the robust assessment process where the provider community clearly identified the benefits people were receiving with the continuation of the exceptional supports. In fact the overwhelming majority (78%) who received continuation of exceptional supports only needed them for up to an additional 6 months. The remaining 12% are still receiving exceptional supports due to the documented benefits that they are receiving. The intent of exceptional supports is that the supports would not become an indefinite part of a person’s support plan is clearly being met; however, these supports may come and go throughout a person’s life on an as-needed basis.

(8) Subject: Unfunded Mandates

(a) Comment: Marie Alagia Cull for Res-Care, Inc., made the following comment:

“The Department should sufficiently fund the SCL program ensure program

requirements enhance rather than detract from the delivery of program services. The requirement of a Registered Nurse to be engaged in the delivery of health services is unnecessary in a nonmedical program. The additional requirements of updating the Health Risk Screening Tool ("HRST") within certain time periods of certain inconsequential events further aggravates the situation. The training curriculum for medication administration training is dependent on DDID scheduled classes which are infrequent and often full, which cause delays and subsequent citation of providers for failing to meet requirements."

(b) Response: Enrollment data supports that the medication administration training occurs once every quarter since January of 2014. At no time was any person placed on a wait list due to capacity issues of the training event. The data does reveal that the capacity for the trainings since January, 2014 was over 50% unused. The lack of attendance is a major concern and some changes will be implemented before the end of 2015. In the future, trainings will be offered statewide by department regional nursing staff. The department will continue to do training quarterly in geographical areas that are more convenient for the training participants.

(a) Comment: Jodi Wilson, Regional Director, Rescare, made the following comment:

"The requirements repeatedly placed upon agencies that are not funded are unduly burdensome and unrealistic (i.e. the shift during reviews to hold agencies more and more accountable for individual health as if they were in ICF-IID OR the lack of funding to help support extremely challenging individuals due to behavioral or medical needs)."

(b) Response: Kentucky is fortunate to have exceptional supports available when extraordinary circumstances related to the assessed needs of a person are indicated The exceptional support process was put in place to allow for additional units or higher rates for needed services to address behavioral or medical challenges.

(9) Subject: Behavior Supports

(a) Comment: Marie Alagia Cull of Res-Care, Inc., made the following comment:

"The reduction in units for behavioral and psychological supports present even greater challenges to obtain quality behavior support services. ResCare's CAKY Programs in Hazard and Louisville, currently under a moratorium, are having difficulty providing supports to people the Department has placed with them because no other service providers will accept these individuals with complex needs. The behavior crisis system for people in community service does not provide agencies with crisis supports other than through administrative meetings and phone calls. No on-site assistance exists which sometimes results in police involvement and hospitalizations. Clinical consultants providing these services are harder to locate since they are receiving less money to provide an increasing level of service. We suggest that the previously funded units for behavioral and psychological supports be reinstated. Further, the Cabinet should develop a statewide team, or regional teams, of behavioral crisis support specialists

available to assist local programs. Protocols to address short term behavioral/psychiatric stabilization should be established to ensure individuals have access to the services they need so they can return to their community.

Based on its experience in other states, ResCare suggests that Kentucky look at the programs in other states such as Kansas and Georgia.

Thank you for the opportunity to comment on this regulation. ResCare representatives are available to meet with you and work through some of these issues."

(b) Response: Thank you for your comments and offer to collaborate on future improvements.

(a) Comment: Jodi Wilson, Regional Director, Rescare, made the following comment:

"Behavior Supports, albeit, funded have very poor quality with no pushback to obtain the supports a person needs. Monthly visits are not completed. Plans are very poor in quality and often over 10 years old. There is no formal functional assessments completed or updated frequently enough for the changes occurring people's lives. Funding for this crucial supports should be increased and the service better managed."

(b) Response: Thank-you for your comments. It is the function of the person centered team to work in conjunction with the positive behavior specialist to ensure appropriate supports are identified and obtained including the need for a new functional assessment when necessary.

(10) Subject: Supported Employment

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons, Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"KAPP remains firmly committed to employment for persons who choose to work, as well as to providing opportunities to explore this important life choice and receive support to attain and maintain a job.

In 2013 we commented regarding the education requirement for Supported Employment Specialist: Requiring that Employment Specialist s possess a Bachelor's degree will only hinder the provider community from providing adequate employment services. Staff turnover is already a burden to providers and this requirement will lessen the pool of candidates especially in rural communities.

We also asked: with most individuals likely obtaining or choosing part---time work, how will the cost of their supports during the other hours be absorbed given the proposed changes in Day Training and the initial funding decrease for that service?

The reality is that despite the decrease in Day Training Rate by 12% and the increase in Supported Employment rate, which was the cornerstone of this waiver, by 85%, the participation numbers did NOT reflect the goal of either service. According to a recent Open Records request to the Department for Medicaid Services, when comparing calendar year 2013 to 2014, the number of SCL participants receiving Supported Employment services increased only very slightly by 38 participants from 345 to 383. Comparatively, Adult Day Training/Day Training for the same period, the number of participants GREW from 3,802 to 4,443, and increase of 641 participants. As a consequence, waiver recipients are increasingly being served in understaffed, underfunded and overcrowded day programs.

Although NOT the intention of the waiver, on paper it appears to be a compliant and progressive regulation, Kentucky's resistance to remove barriers to the KEY services for a meaningful day and true community access has resulted in fewer choices. Additionally, the cut in the rates by 15% of those programs has resulted in lower quality, higher staff to participant ratios and fewer opportunities for community inclusion."

(b) Response: Although the number of participants in day training has increased, when considering the overall increase in waiver participants and enrollment in day training, the percentage of waiver participants utilizing day training has decreased from 90% in 2013 to 87% in 2015. The number of people utilizing community access is actually increasing – 294 people used this service in 2014 and 355 in 2015.

Since focusing on community employment, the number of people with disabilities in Kentucky who are working in the community has risen from one of the lowest rates in the country to the national average of 18%.

In addition, the stated goal for increasing the employment of SCL2 participants canvassed through the National Core Indicators was to increase the number of participants working in the community by 5%. After accounting for uniform (5%) job losses across both Kentucky and the entire nation caused by the economic recession, Kentucky has rebounded to record the targeted 5% increase in the community employment of SCL participants from the post-recession low (2013/14 data).

Since Medicaid is the funder of last resort, 95% of the waiver participants newly entering the workforce will receive employment services through the Office of Vocational

Rehabilitation for at least 6 months up to about 24 months before their first waiver prior authorization for employment is requested. This means that only a handful of waiver participants who decided to seek community employment upon entering SCL2 are actually being funded through the waiver. We have attempted to obtain an estimate of the number of "new" VR clients who receive waiver services but that number is not tracked.

While we recognized that our previous process for delivering employment services to waiver participants was flawed, we had no idea exactly how flawed it was until we visited supported employment providers and conducted utilization reviews to determine the efficacy of the supports being provided as supported employment. The result of the utilization review was the recognition that a large percentage of persons receiving supported employment services had actually completely mastered their jobs and were receiving supports 100% of the time due to guardian's requests, an incorrect assessment of the crisis needs of the individual, and a lack of understanding of the requirements of supported employment. Recognition of these facts resulted in the conversion of a large number of supported employment prior authorizations to adult day training or personal assistance.

If there is a change in the person's disability or the emergence of a secondary disability that significantly impacts a person's ability to work, the person is entitled to receive a second set of services through vocational rehabilitation.

Prior to the implementation of SCL2 this reality was not addressed. When we initiated this process with SCL2, the percentage of requests receiving a second segment of service through OVR went from negligible to around 40%. It has since settled in between 30-35% on average.

When comparing the supported employment rate and the day training rate, even with the increase in the supported employment rate for SCL and the reduction of the adult day training rate, the provider income generated per staff member for adult day training still exceeds the income generated for supported employment.

Supported employment is delivered on a one to one basis and generates $41 per hour of service per staff member.

Even the most conservative estimates place the average staff to participant ratio for adult day treatment at one staff member to five participants. With that ratio adult day training generates $48.40 per hour of service per staff member.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons, Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD,

Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"We request that there is an allowance and realistic understanding for ongoing supported employment for someone who may always require supports in order to maintain his/her job. It may be funded lower than the typical SE rate, but higher than the Day Training rate, which only reimburses the provider $8.80 per hour. That is an insufficient rate for any 1:1 service. If sufficiently justified in the participant's service plan, this support should be approved for 1 year without further question. If the person has a job regardless of requiring ongoing support, neither they nor the team should have to justify that every 3-6 months. It is not a failure to have a disability or need ongoing supports in a long-term supports and services waiver."

(b) Response: An allowance for on-going supported employment for persons who need to work in the community already exists.

Supported employment is a person-centered support. This means that the actual needs of the person determine the amount and configuration of the supports that are necessary for the person to live their life as independently as is possible.

The amount of support to be provided is defined by and justified in the Long-Term Employment Support Plan. The person working in the community may receive the amount of support that is justified in the plan. They are not limited to six hours per month.

In every Long Term Employment Support Plan there is the expectation that the person will be working toward increased independence. For that reason a fading plan is required.

The referenced rate of $8.80 per hour only applies when additional supports in the workplace are not justified in the long-term employment support plan.

The protocol for supported employment is as follows:

- Participants receive the amount of support that they need to maintain their employment; but nothing beyond what is needed. The needed support may be comprised of a number of SCL services.
- People needing assistance completing the specific tasks that they have been hired to complete should receive supported employment services as defined in their Long-Term Employment Support Plan (LTESP). There should be a fading plan included in the LTESP to assist the consumer to work toward independence.
- People needing direct assistance due to personal care, behavioral, or medical

needs including transportation (that cannot be provided using other Medicaid funded means) that are documented by the support team as being an ongoing current need of the consumer should receive personal assistance if they live in their own residence or with their own family (not a family home provider).

- If they receive residential services, including adult foster care (AFC) or family home provider (FHP), this function is part of the definition of residential services. The fact that the residential provider's contract with an AFC or FHP does not include this type of transportation is immaterial. The residential provider must acquire the transportation by other means.
- People needing assistance because "something might happen" at the request of the consumer's family or guardian or at the request of the employer should receive day training services. Typically the provision of services in this situation indicates a poor job match and, if the consumer wishes, should be replaced with a better matched job. The delivery of services under these circumstances is also contrary to the goals of the program, which are to help people live their lives as part of the community.

All people receiving waiver services in the community should receive at least six hours of supported employment in order to maintain their employment.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons, Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"We request to increase the twenty-four units of SE each month to a customized and realistic number. This is only 6 hours per month and few employers want to hire someone for so few hours."

(b) Response: This requirement does not restrict the number of hours a participant can work. Supported employment is intended to help people with disabilities work in the community with as little paid staff assistance as is possible. Their goal should be to maximize the amount of time they are working in the community without staff assistance.

Supported employment is a person-centered support. This means that the actual needs of the person determine the amount and configuration of the supports that are

necessary for the person to live their life as independently as is possible.

The amount of support to be provided is defined by and justified in the Long-Term Employment Support Plan. The person working in the community may receive the amount of support that is justified in the plan. They are not limited to six hours per month.

In every Long Term Employment Support Plan there is the expectation that the person will be working toward increased independence. For that reason a fading plan is required.

Six hours per month (24 units) is the minimum amount of supported employment that a person working in the community should receive.

These supported employment units should be used to monitor the person's work situation and address workplace situations before they have the opportunity to threaten the person's employment.

These units should not be used to provide one on one support in the workplace unless it is necessary and justified in the Long-Term Employment Support Plan.

If a person's opportunity to work is limited to the minimum allowable amount of supported employment (six hours per month) the support is not person centered. It is defined purely by the number of units that the provider may be approved for payment.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons, Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"Supported Employment is a must in order to meet the CMS Final Rule and move forward with community inclusion. The new SE definition adding "any hours of paid community employment" to the 16-hour total per day limit. If a participant is working in the community and during that time they are not receiving supported employment services billed through the waiver that time should not be taken away from their potential service time while they are not working that day."

(b) Response: Previous versions of the SCL regulation incorrectly referenced the receipt of supported employment services within both the 16 hour per day and 40 hour per week limit. The revised SCL regulation corrects that error.

The combination of adult day training, community access, and the hours the person works in the community should not exceed 16 hours per day.

The combination of adult day training and the hours the person works in the community should not exceed 40 hours per week.

This allows persons receiving waiver supports to have un-programmed time for rest and relaxation.

(11) Subject: Community Access

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons, Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“Although providers were very excited about the concept of Community Access, especially with the decrease in Day Training rate and total elimination of an off-site day training rate, our concerns initially were the unnecessary degree and credentialing requirements for staff to do this service and also the fact that it was labeled an “impact service.” Impact Service is defined in regulation as “a service designed to decrease the amount of paid supports a participant requires as the participant becomes a) more independent and b) less reliant on an employee. This automatically unfairly disqualifies a large majority of people in the waiver. There is nothing wrong with having neither a disability, nor needing long term supports and services in a long-term supports and services waiver! It’s not a failure if someone continues to need supports, does not become independent and needs to rely on paid supports.

Redistribution of funding from DT services to Community Access services is fundamentally flawed. There is no empirical basis to support the establishment of this time-limited service. There is no incentive for service agencies to even provide this service. The decrease in funding to DT services, which continue to provide on and off-site supports has affect some providers’ ability to implement increased off-site activities

due to the subsequent rise in transportation costs while incurring decreased reimbursement. The rises in cost and the decreases in revenue are unsustainable.

KAPP's suggestion for the past 2 years has been to remove the degreed and credentialing requirements for staff providing Community Access. We also have requested the term "impact service" be removed. Once removed, these barriers would allow providers to increase services and for participants to all be eligible for 1:1 or 1:2 supports in the community. Everyone deserves these supports, not just an elite few. If we truly want congregate Day Training settings to decrease in population, we MUST remove the barriers to allow Community Access! 1:1 and 1:2 supports give the participant the absolute best changes to achieve their outcomes and integrate into their communities.

The belief that 1:1 or 1:2 staff supports for people with significant intellectual disabilities who are receiving Community Access (or Supported Employment) services can be significantly reduced or even faded out completely over time is a dangerous assumption for a significant majority of this population. Participation in Community Access compared to Community Living Supports under SCL1, has plummeted. This reduced participation is a direct consequence of both the aforementioned credentialing issue as well as the difficulty in obtaining approval of person-centered service plans that will allow for the provision of 1:1 staffing for the duration necessary to keep participants actively engaged and most importantly safe.

Although NOT the intention of the waiver, on paper it appears to be a compliant and progressive regulation, Kentucky's resistance to remove barriers to the KEY services for a meaningful day and true community access has resulted in fewer choices. Additionally, the cut in the rates by 15% of those programs has resulted in lower quality, higher staff to participant ratios and fewer opportunities for community inclusion."

(b) Response: Although the number of participants in day training has increased, when considering the overall increase in waiver participants and enrollment in day training, the percentage of waiver participants utilizing day training has decreased from 90% in 2013 to 87% in 2015. The number of people utilizing community access is actually increasing – 294 people used this service in 2014 and 355 in 2015.

Community access is available to all waiver participants. It is not necessarily expected that a participant would achieve total independence within a natural setting within six months. However, within the six month prior authorized period, concrete objectives specified in the plan should have been accomplished. If additional supports are needed to advance the person's ultimate outcome, they may be requested through a plan modification.

The expectation is that careful and deliberate person centered planning will result in supports that will result in customized supports tailored to the specific needs and desires of the person involved. This will vary immensely from person to person and may include paid or unpaid supports.

Community access services are designed to enable people to have increased access to community resources and offer opportunities for people to develop personal social networks by building friendships and making connections with other people in their local communities. Impact services such as community access are expected to have a significant effect on a person's ability to engage with other people in the local community. Prior authorizations for this service are limited to up to six months per request; however, should the person require ongoing community access service beyond a six month prior authorization, the person centered team may request ongoing services based on the person's ongoing need for assistance to connect with community members. The service provision should decrease as the person develops the skills needed to maintain the connection within the community. Other SCL services, such as day training and residential services should be utilized, if needed, when community access services are withdrawn, to assist the person with any additional needs, such as personal care, financial management or transportation.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons, Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"The Community Access service was developed upon the result from the SCL Listening Tour the department conducted in 2009, when individuals who attended stated they wanted to be more involved in their communities and make friends. It was initially perceived that Community Access would be the solution to the problem of people not feeling connected with their communities. Reality is that Community Access as a service has failed because it continues to be defined as an impact service, which means it is a time limited service with the goal of lesser reliance of paid formal supports and strengthening of natural supports. The result has been that Community Access is only a service for a very elite group of participants in the waiver. This is NOT person---centered and in fact is a very exclusive service. If a person needs staff assistance or is unable to be left alone due to safety, behavior and/or medical concerns they are not perceived as a good candidate for CA. This further reduces the flexibility for a person to make decisions in their life in regards to services. Not every person in the SCL waiver can receive this service, leaving their ONLY options for a "meaningful day"…an underfunded, overcrowded, understaffed Day Training model OR worse, sitting at home. There is the option of Personal Assistance, but that is not available for persons

receiving Residential Services, which most people in the SCL program are in residential settings. What has resulted is an increase in Day Training services while impact services have not grown. The other (most simple) option is to simply remove the requirement establishing Community Access as an impact service. As we have confirmed with Medicaid it is not a requirement to include it as a caveat to the service. If the Cabinet replaced the tiered system of Supported Employment and allow the Person Centered Team to determine support needs, then the service would be a much more inclusive and accessible service."

(b) Response: Community access is available to all waiver participants. It is not necessarily expected that a participant would achieve total independence within a natural setting within six months. However, within the six month prior authorized period, concrete objectives specified in the plan should have been accomplished. If additional supports are needed to advance the person's ultimate outcome, they may be requested through a plan modification.

The expectation is that careful and deliberate person centered planning will result in supports that will result in customized supports tailored to the specific needs and desires of the person involved. This will vary immensely from person to person and may include paid or unpaid supports.

Community access will remain an impact service. It is designed as a bridge to connect and empower a participant to develop networks of natural support and become less reliant on formal supports. Impact services are not intended as restricted services. Services such as community access are expected to have a significant effect on a person's ability to engage with other people in the local community. Community access services are designed to enable people to have increased access to community resources and offer opportunities for people to develop personal social networks by building friendships and making connections with other people in their local communities. Impact services, such as community access, are expected to have a significant effect on a person's ability to engage with other people in the local community.

Prior authorizations for this service are limited to up to six months per request; however, should the person require ongoing community access service beyond a six month prior authorization, the person centered team may request ongoing services based on the person's ongoing need for assistance to connect with community members.

The service provision should decrease as the person develops the skills needed to maintain the connection within the community. Other SCL services such as day training and residential services should be utilized, if needed, when community access services are withdrawn, to assist the person with any additional needs such as personal care, financial management, or transportation.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;

Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons, Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"In theory, Community Access has the potential to be a great service. It provides an opportunity for individuals who want to be more involved in their respective communities while also developing natural supports to increase their independence. Reality of what we have found is that this service, much like Supported Employment, targets a small percentage of individuals in the SCL waiver. The biggest barriers to success that we have found is not meeting the staffing requirements, it has been meeting the language of the regulations when it comes to Community Access as an impact service. For starters, the service is limited to six (6) month approvals. It is not guaranteed that you will receive an extension of services. Secondly, even with the 6-month approval, it is difficult for Community Access Specialist to transition persons who need more intense supports to a setting where they are independent with natural supports in such a small time period. Third, the service is not designed to be an alternative to a day program setting, which is what we have seen that the majority of individuals on the SCL waiver have wanted. Most memberships, organizations, and clubs do not meet during the time of 8a - 4p (normal day program hours). Yet, agencies still receive referrals from Case Managers for Community Access for persons to hold memberships and be active within their community because the person does not want to attend the day program. The choice is either Community Access or Supported Employment to take the place of the traditional 40 hours a week of day program. If you choose to not want seek competitive employment or caught within the red tape of the OVR process, not a candidate to be independent in a community setting with only natural supports due to various reasons, and do not want to attend a day program five days a week, there is nothing else for you. Interesting that the waiver that offers programs to promote inclusion, integration, and choice potentially alienates and segregates people more from their communities (especially if they live in a residential setting). In essence, impact services such as Community Access and Supported Employment services are needed in the waiver, but there is a missing link of services. If the end goal is to promote community inclusion, then there has to be a service that can reach the greater population within the SCL waiver to be a part of their communities rather than only rely on the residential provider to do so in a group setting with two other individuals with disabilities. Again, are we not trying to get away from institutional-type services (i.e. group---based outings)?

Furthermore, with the increased focus on Person Centered Planning and the Service Plan requirements, included in the Summary of Changes must reflect the need for "full

access for individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS." It also specifics "individually identified goals and desired outcomes" and to "identify the individual and/or entity responsible for monitoring the plan." KAPP supports the spirit of the CMS rule and Person Centered Planning Processes. These goals apply to everyone in the waiver, not a select few that can qualify for an IMPACT SERVICE. To meet the goals outlined in the CMS rule and moving forward in our 1915c waiver, participants must have access to the service of 1:1 or 1:2 to effectively achieve these goals and outcomes. A case manager can write a wonderful person centered plan, but if a person's only option is an underfunded, overcrowded, understaffed Day Training center, how can the plan be expected to succeed for them? How can 1 staff support up to 10 participants with different support needs to meet their goals? Everyone deserves 1:1 or 1:2 supports, not just a select few that qualify for an IMPACT SERVICE.

Request that the term "impact service" be removed from regulatory language for Community Access. It causes the service to be discriminatory to only those participants who can and desire to live independently. Not every person in the SCL waiver can or wants to do that, leaving their ONLY options for a "meaningful day"…an underfunded, overcrowded, understaffed Day Training model OR worse, sitting at home. For Kentucky to sincerely comply with the CMS Rule in the next 4 years, the barriers to true Community Access for everyone must be removed."

(b) Response: Community access is available to all waiver participants. It is not necessarily expected that a participant would achieve total independence within a natural setting within six months. However, within the six month prior authorized period, concrete objectives specified in the plan should have been accomplished. If additional supports are needed to advance the person's ultimate outcome, they may be requested through a plan modification.

The expectation is that careful and deliberate person centered planning will result in supports that will result in customized supports tailored to the specific needs and desires of the person involved. This will vary immensely from person to person and may include paid or unpaid supports.

Community access will remain an impact service. It is designed as a bridge to connect and empower a participant to develop networks of natural support and become less reliant on formal supports. Impact services are not intended as restricted services. Services such as community access are expected to have a significant effect on a person's ability to engage with other people in the local community. Community access services are designed to enable people to have increased access to community resources and offer opportunities for people to develop personal social networks by building friendships and making connections with other people in their local communities. Impact services, such as community access, are expected to have a significant effect on a person's ability to engage with other people in the local

community.

Prior authorizations for this service are limited to up to six months per request; however, should the person require ongoing community access service beyond a six month prior authorization, the person centered team may request ongoing services based on the person's ongoing need for assistance to connect with community members.

The service provision should decrease as the person develops the skills needed to maintain the connection within the community. Other SCL services such as day training and residential services should be utilized, if needed, when community access services are withdrawn, to assist the person with any additional needs such as personal care, financial management, or transportation.

(12) Subject: Residential

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons, Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"In 2013 KAPP was supportive of "the addition of progressive residential options in the waiver, such as Technology Assisted and Shared Living. KAPP understands the rate adjustments in the more traditional models, Family Home Providers and staffed residences. The concern is that these modest increases will be quickly absorbed and counteracted by the increase in administrative burdens and costs, associated with additional waiver requirements and unfunded mandates."

(b) Response: Thank you for your comments. No rate changes are being considered for the regulation at this time.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons, Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director

Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"The expectations for Staffed Residence include: no more than three participants, ensuring the participant has privacy in the sleeping or living unit in the residential setting, an option for a private unit in a residential setting, a unit with lockable entrance doors and with only the individual and appropriate staff having keys to those doors, a choice of roommates or housemates, the freedom to furnish or decorate the participant's sleeping or living units, visitors of the participant's choosing at any time and access to a private area for visitors, be considered physically accessible that is easy to approach, enter, operate or participate in a safe manner and with a dignity by a person with or without a disability and that meets the American Disability Act, being for a participant who requires a 24 hour a day, intense level of support with no more than 5 unsupervised hours per day per participant, to promote independence and based on the needs of the participant as determined by the participant's person centered team. The current expectations of DDID and many case managers are that each individual be served independently regardless of the other individuals living in the home or their wishes. This is not the expectation in a family home provider setting or in any home for that matter. If an individual and/or their guardian chooses this option of a staffed residence which the state supports in the waiver, the specific wants and needs of an individual cannot be met concurrently at the residential rate, which funds 1 staff per 3 people. It is concerning that the assumption is the only person of importance is the individual without any concern to the others living in the home. We should be advocating for each individual to get what he or she need with respect to the environment in which they have chosen to live and for the people they live with."

(b) Response: Each waiver recipient who is prior authorized to receive a residential service is entitled to receive the support defined by the regulation. This level of support does not, in any way, preclude the possibility of supporting each person living in the home to exercise choice and does not dictate staffing ratios. Staffing should be based on the support needs of each person receiving services which is informed by the person centered planning team. Providers receive reimbursement for each person supported.

(13) Subject: Case Management

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons, Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director

Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"In 2013 KAPP commented: While we acknowledge the conflict---free case management model requirement in the new waiver, the need to ensure freedom of choice is greater than ever. We expressed at the time that the decision to require conflict---free case management actually limits choice.

We also commented on the Case Management rate reduction: The description of additional responsibilities and the anticipated authoritative role for Case Managers, not to mention increased training requirements, seem to constitute a rate INCREASE or at least maintenance of the rate. Instead, the rate for CM decreased 15%, despite a significant increase in work and responsibility. KAPP predicted this would cause higher caseloads resulting in lower quality services.

KAPP's requests for the past 2 years have been restore the case management rate (especially in light of the ADDITIONAL responsibilities placed upon them through the CMS Final Rule requirements.)

Some service agencies have they are required to coordinate care, send frequent reminders to Case Managers (CM) for needed documents, include them in follow up to incidents (for which they are unavailable), and send requested documents to CM rather than the CM visiting with the person and reviewing the necessary documents at that time. None of the residential or DT time spent on case coordination is reimbursable. In some instances, Case Managers are employed by multiple organizations an inherent complication to the principle of "conflict free" case management since it is impossible to determine a Case Manager's true affiliation.

An unintended consequence of the waiver model seems to have pitted Case Managers and Service Providers against each other, rather than to encourage them to collaborate for the person's best interest and outcomes."

(b) Response: The case manager's role is to advocate for standards that promote outcomes of quality for people in the SCL program. They are to encourage and advocate for person centered services and supports that are designed to meet the needs of each person. They facilitate the person centered team meetings and communications in order to help ensure appropriate decisions are being made and that appropriate services and supports are in place. All members of a person's team should work collaboratively so people have support to participate in everyday community activities. Agency supervisors should maintain oversight of these efforts and work together for successful outcomes.

The adjustment of the rates was made to better align Kentucky's rates with the national median payment ranges of $100-250.00 per month as reported by the National Association of State Directors of Developmental Disability Services.

SUMMARY OF STATEMENT OF CONSIDERATION
AND
ACTION TAKEN BY PROMULGATING ADMINISTRATIVE BODY

The Department for Medicaid Services (DMS) has considered the comments received regarding 907 KAR: 12:020 and is not amending the administrative regulation.